BEAUTY FOR ASHES COUNSELING CENTER
Renee Lister Farley, LPC
515 North Cedar Ridge Drive, Suite 7-E
Duncanville, Texas 75116
214-417-8706
972-224-2429 fax

AUTHORIZATION FOR SERVICES TO MINOR CHILD

I, _____, hereby **authorize:**
(print name of Parent/Guardian giving consent)

my child,_____
(print name of minor child)

at the following address:_____

_____

and/or telephone:_____

to be evaluated and provided treatment services by the following clinician:

RENEE LISTER FARLEY, LPC

_____
(print clinician name)

The purpose of the services is : for assessment and to facilitate treatment planning/progress; provide case management and follow-up; expedite medical coverage benefits; coordinate ongoing counseling services and/or for

_____

I understand that my records are protected under federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that, under Texas law, it may be a mental health professional's duty to warn and/or report to authorities actual or intended child abuse or neglect, or homicide or suicide. I also understand that I may revoke this consent (in writing) at any time. Such revocation will not apply to information already released by this signed consent.

This consent will automatically expire upon fulfillment of the purposes stated above. This consent in any event will expire twelve (12) months from the date signed.

I further acknowledge that the authorization for services was fully explained to me and this consent is given of my own free will.

SIGNATURE:_____ DATE:_____

WITNESS:_____ DATE:_____